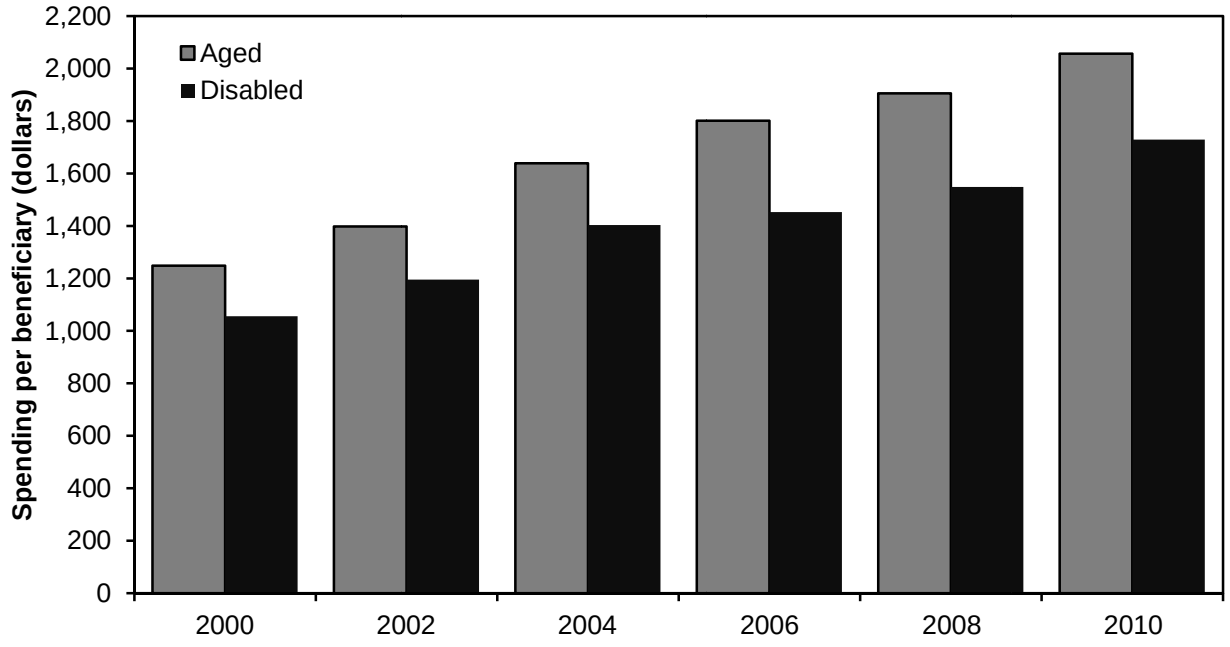
SECTION 7

Ambulatory care

Physicians
Hospital outpatient services
Ambulatory surgical centers
Imaging services

Chart 7-1. Medicare spending per FFS beneficiary on physician fee-schedule services, 2000–2010



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance. The category "disabled" excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries age 65 or over are included in the aged category.

Source: 2011annual reports of the Boards of Trustees of the Medicare trust funds.

- Physicians and other health professionals perform a broad range of services listed on the Medicare physician fee schedule, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. In addition to physicians, these services may be provided by other health professionals (e.g., nurse practitioners, chiropractors, and physical therapists).

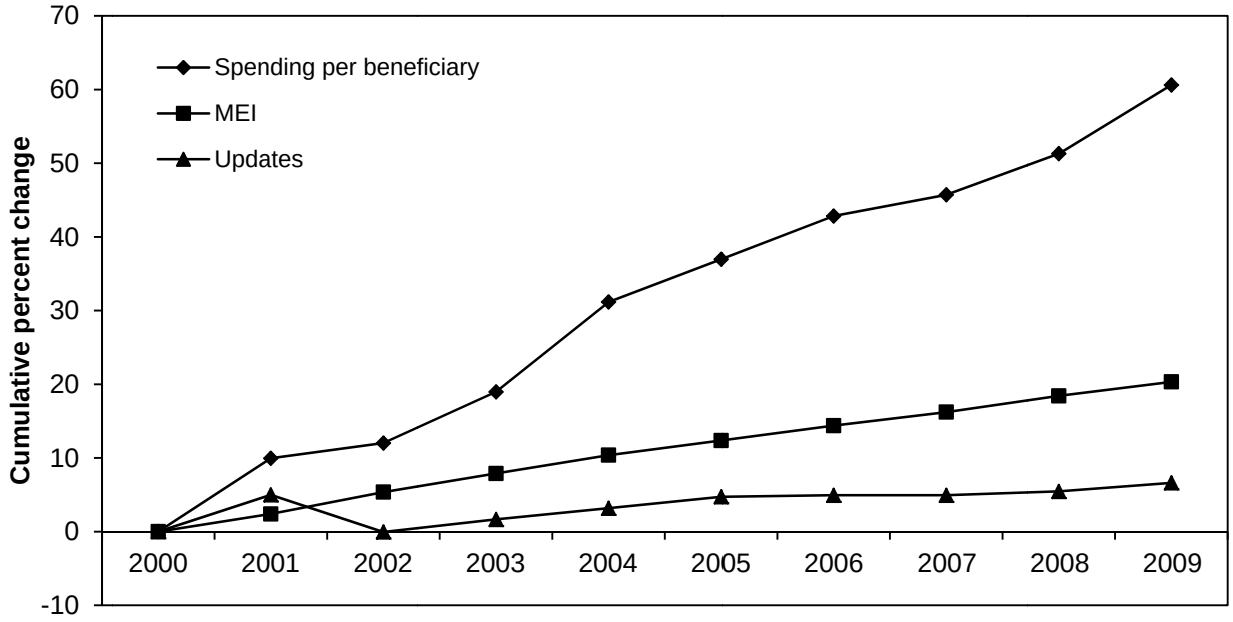
- Fee-for-service (FFS) spending per beneficiary for physician fee-schedule services has increased annually. During the decade between 2000 and 2010, Medicare spending per FFS beneficiary on these services grew 64 percent.

- Growth in spending on physician fee-schedule services is one of several contributions to Part B premium increases over this time period.

- Per capita spending for disabled beneficiaries (under age 65) is lower than per capita spending for aged beneficiaries. In 2010, for example, per capita spending for disabled beneficiaries was $1,729 compared with $2,056 for aged beneficiaries.

- Spending data for 2011 are not available.

Chart 7-2. Volume growth has raised physician spending more than input prices and payment updates, 2000–2009

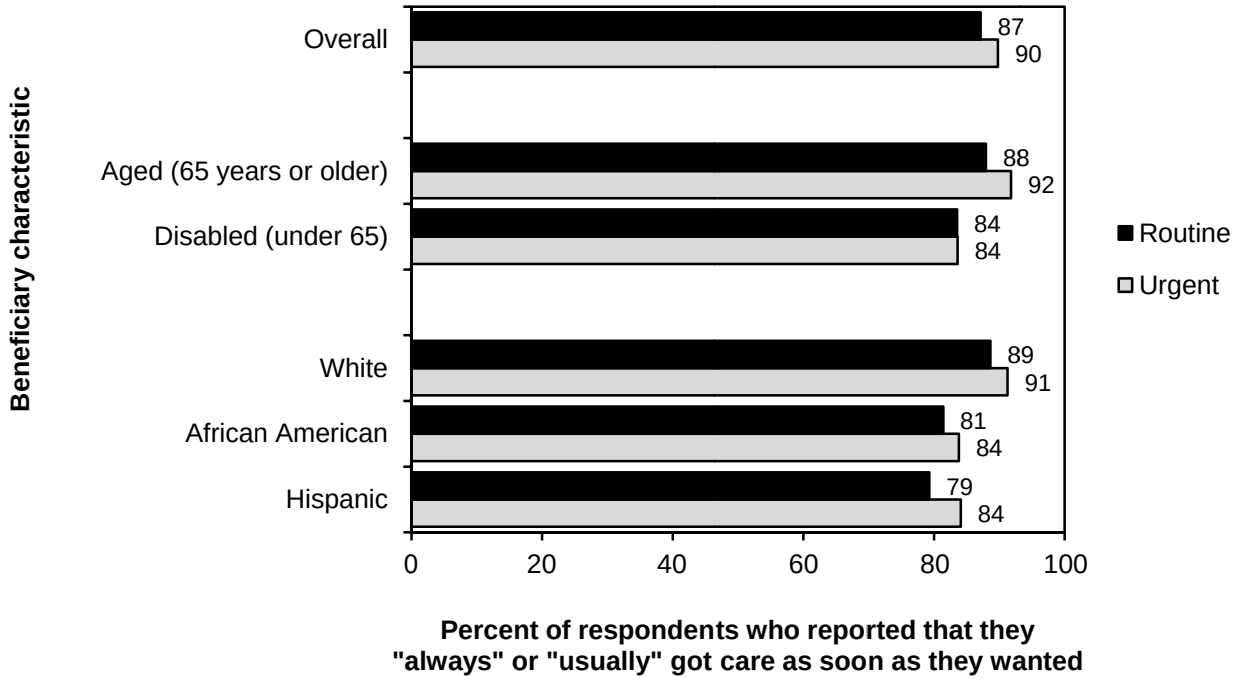


Note: MEI (Medicare Economic Index).

Source: 2010 annual report of the Boards of Trustees of the Medicare trust funds, IHS Global Insight data through second quarter of 2010, and data from the Office of the Actuary.

- During the 10-year period ending in 2009, Medicare spending for physician services—per beneficiary—increased by 61 percent.
- Medicare spending on physician services grew much more rapidly over this period than both the payment rate updates and the Medicare Economic Index (MEI). Physician fee schedule payment updates totaled 7 percent, and the MEI increased 20 percent.
- Growth in the volume of services provided contributed significantly more to the rapid increase in Medicare spending than payment rate updates. Both factors—updates and volume growth—combine to increase physician revenues.

Chart 7-3. Most beneficiaries report that they can always or usually get timely care, 2010



Note: In the survey, routine care refers to appointments in doctors' offices or clinics that are not for care needed "right away." Urgent care refers to care needed "right away" for an illness, injury, or condition. Nonapplicable respondents (e.g., those who did not seek routine or urgent care in the last six months) were excluded.

Source: MedPAC analysis of CAHPS® (Consumer Assessment of Healthcare Providers and Systems®) for fee-for-service Medicare, 2010.

- Overall, 87 percent of Medicare beneficiaries who reported making an appointment for routine care at a doctor's office or clinic said that they always or usually got care as soon as they wanted. For beneficiaries who reported needing urgent care in a clinic, emergency room, or doctor's office, 90 percent reported that they always or usually got care as soon as they wanted.

- Compared with beneficiaries age 65 or older, those under age 65 and eligible for Medicare on the basis of disability were less likely to report that they always or usually got routine or urgent care as soon as they wanted.

- Smaller percentages of African American and Hispanic beneficiaries reported that they always or usually got care as soon as they wanted, compared with White beneficiaries.

Chart 7-4. Medicare beneficiaries report better ability to get timely appointments with physicians, compared with privately insured individuals, 2007–2010

	Medicare (age 65 or older)				Private insurance (age 50–64)			
Survey question	2007	2008	2009	2010	2007	2008	2009	2010
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"								
For routine care								
Never	75%*	76%*	77%*	75%*	67%*	69%*	71%*	72%*
Sometimes	18*	17*	17*	17*	24*	24*	22*	21*
Usually	3	3*	2*	3*	4	5*	3*	4*
Always	3	2	2	2	3	2	3	3
For illness or injury								
Never	82*	84*	85*	83%*	76*	79*	79*	80%*
Sometimes	13*	12*	11*	13*	17*	16*	17*	15*
Usually	3	1	2	2	3	2	2	2
Always	2	1*	1	1*	3	2*	2	2*

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in years 2006 and 2007, 3,000 in 2008, and 4,000 in years 2009 and 2010. Sample sizes for individual questions varied.
* Indicates a statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone surveys, conducted in 2007, 2008, 2009, and 2010.

- Most Medicare beneficiaries have one or more doctor appointments in a given year. Therefore, one access indicator we examine is their ability to schedule timely appointments.
- Medicare beneficiaries report better access to physicians for appointments compared with privately insured individuals age 50 to 64. For example, in 2010, 75 percent of Medicare beneficiaries and 72 percent of privately insured individuals reported "never" having to wait longer than they wanted to get an appointment for routine care.
- Medicare beneficiaries also report more timely appointments for injury and illness compared with their privately insured counterparts.
- As expected, appointment scheduling for illness and injury is better than for routine care appointments for both Medicare beneficiaries and privately insured individuals.

Chart 7-5. Medicare and privately insured patients who are looking for a new physician report more difficulty finding one in primary care, 2007–2010

	Medicare (age 65 or older)				Private insurance (age 50–64)			
Survey question	2007	2008	2009	2010	2007	2008	2009	2010
Looking for a new physician: "In the past 12 months, have you tried to get a new primary care doctor?"								
Yes	9%	6%	6%	7%	10%	7%	8%	7%
No	91	93	93	93	90	93	92	93
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it…"								
Primary care physician								
No problem	70*	71	78	79*	82*	72	71	69*
Small problem	12	10	10	8	7	13	8	12
Big problem	17	18	12*	12	10	13	21*	19
Specialist								
No problem	85	88	88	87*	79	83	84	82*
Small problem	6	7	7	6*	11	9	9	11*
Big problem	9	4	5	5	10	7	7	6

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in years 2006 and 2007, 3,000 in 2008, and 4,000 in years 2009 and 2010. Sample sizes for individual questions varied.
* Indicates a statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone surveys, conducted in 2007, 2008, 2009, and 2010.

- In 2010, only 7 percent of Medicare beneficiaries and 7 percent of privately insured individuals reported looking for a new primary care physician. This finding suggests that most people are either satisfied with their current physician or did not have a need to look for one.

- Of the 7 percent of Medicare beneficiaries who were looking for a new primary care physician in 2010, 20 percent reported problems finding one—12 percent reporting their problem as "big" plus 8 percent reporting their problem as "small." Although this number amounts to less than 2 percent of the total Medicare population reporting problems, the Commission is concerned about the continuing trend of greater access problems for primary care.

  Of the 7 percent of privately insured individuals who were looking for a new primary care physician in 2010, 31 percent reported problems finding one—19 percent reporting their problem as "big" plus 12 percent reporting their problem as "small." The difference in the percentage experiencing a "big problem" finding a primary care physician between the Medicare and privately insured groups was statistically significant in 2009.

- For 2010, Medicare beneficiaries and privately insured individuals were more likely to report problems accessing primary care physicians compared with specialists.

Chart 7-6. Access to physician care is better for Medicare beneficiaries compared with privately insured individuals, but minorities in both groups report problems more frequently, 2010

	Medicare (age 65 or older)			Private insurance (age 50–64)		
Survey question	All	White	Minority	All	White	Minority
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	75%*	76%*	74%*	72%*	73%*†	66%*†
Sometimes	17*	17*	17*	21*	20*	23*
Usually	3*	3	3*	4*	4	6*
Always	2	2	3	3	2	4
For illness or injury						
Never	83%*	84%*†	80%*†	80%*	81%*†	74%*†
Sometimes	13*	12	14*	15*	14†	20*†
Usually	2	2	2	2	2	2
Always	1*	1*†	2†	2*	2*	3

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in years 2006 and 2007, 3,000 in 2008, and 4,000 in years 2009 and 2010. Sample sizes for individual questions varied.
* Indicates a statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.
† Indicates a statistically significant difference by race within the same insurance coverage category in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone surveys, conducted in 2010.

- In 2010, Medicare beneficiaries reported better access to physicians for appointments compared with privately insured individuals age 50 to 64.
- Access varied by race, with minorities more likely than Whites to report access problems in both insurance categories. For example, in 2010, 84 percent of White Medicare beneficiaries reported "never" having to wait longer than they wanted to get an appointment for an illness or injury compared with 80 percent of minority beneficiaries.
- Although minorities experienced more access problems, minorities with Medicare were less likely to experience problems compared with minorities with private insurance.

Chart 7-7. Differences in access to new physicians are most apparent among minority Medicare and privately insured patients who are looking for a new specialist, 2010

	Medicare (age 65 or older)			Private insurance (age 50–64)		
Survey question	All	White	Minority	All	White	Minority
Looking for a new physician: "In the past 12 months, have you tried to get a new primary care doctor?"						
Yes	7%	7%	7%	7%	7%	6%
No	93	93	92	93	93	94
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it…"						
Primary care physician						
No problem	79*	80*	76	69*	69*	67
Small problem	8	7	9	12	11	15
Big problem	12	12	14	19	19	18
Specialist						
No problem	87*	89*†	78†	82*	83*†	73†
Small problem	6*	5*†	11†	11*	11*	14
Big problem	5	5	9	6	5†	13†

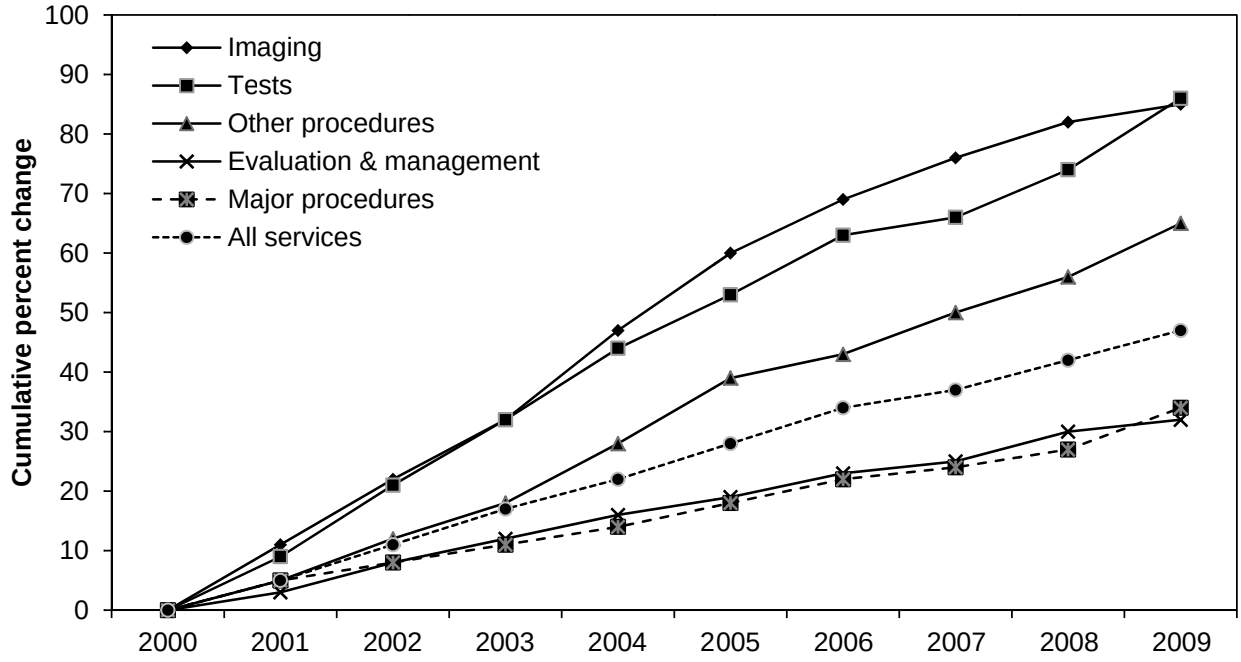
Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in years 2006 and 2007, 3,000 in 2008, and 4,000 in years 2009 and 2010. Sample sizes for individual questions varied.
* Indicates a statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.
† Indicates a statistically significant difference by race within the same insurance coverage category in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone surveys, conducted in 2010.

- Among the small percentage of Medicare beneficiaries and privately insured individuals looking for a specialist, minorities were more likely than Whites to report problems finding one. For example, in 2010, 89 percent of White Medicare beneficiaries reported "no problem" finding a specialist, compared with 78 percent of minority beneficiaries.

- Although minorities experienced more access problems, minorities with Medicare were less likely to experience problems compared with minorities with private insurance.

Chart 7-8. Continued growth in volume of physician services per beneficiary, 2000–2009



Note: Volume is units of service multiplied by relative value units from the physician fee schedule. Volume for all years is measured on a common scale, with relative value units for 2009.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

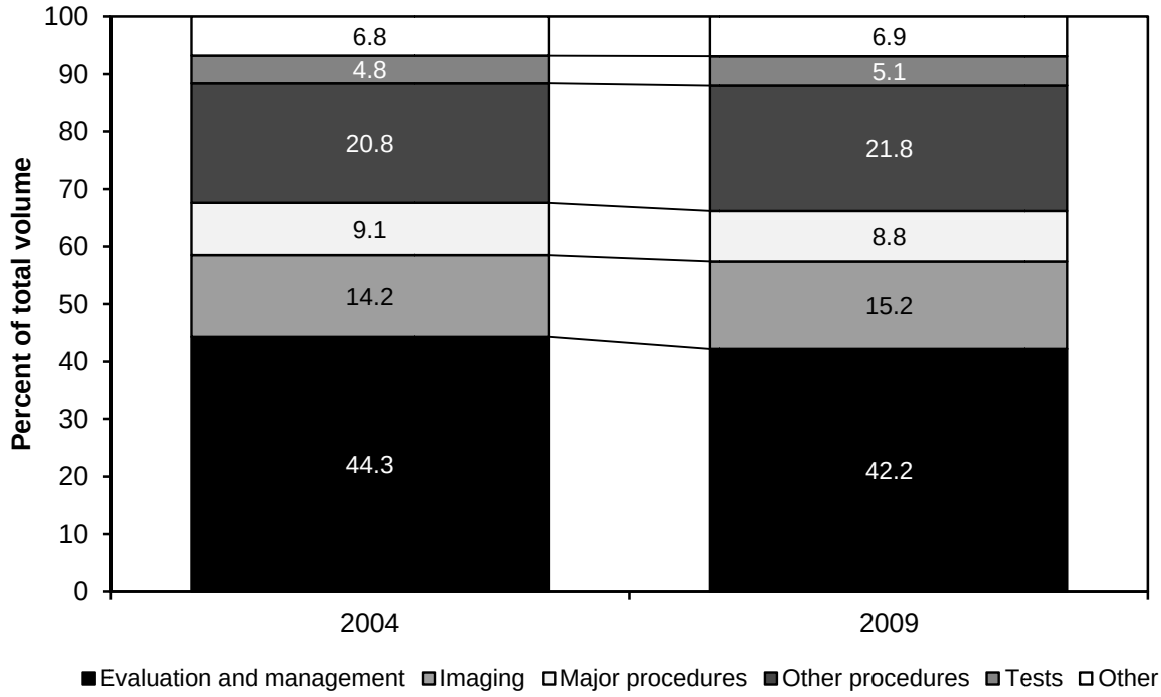
- The volume of physician services per beneficiary has continued to grow from year to year, with some services growing much more than others.

- From 2000 to 2009, the volume of physician services grew by 47.0 percent. By specific types of services, imaging, tests, and "other procedures" (procedures other than major procedures) each grew at a rate of 65 percent or more. The comparable growth rates for major procedures and evaluation and management services were only 34 percent and 32 percent, respectively.

- Volume growth has slowed in recent years but remains positive. From 2008 to 2009, services in the tests category grew the most: They increased 7.4 percent. Other procedures was next, at 5.5 percent, followed by major procedures (5.3 percent), imaging (2.0 percent), and evaluation and management (1.7 percent).

- Volume growth increases Medicare spending, squeezing other priorities in the federal budget and requiring taxpayers and beneficiaries to contribute more to the Medicare program. Overall volume increases translate directly to growth in both Part B spending and premiums. They are also largely responsible for the negative updates required by the sustainable growth rate formula. Rapid volume growth may be a sign that some services in the physician fee schedule are mispriced.

Chart 7-9. Shifts in the volume of physician services, by type of service, 2004–2009



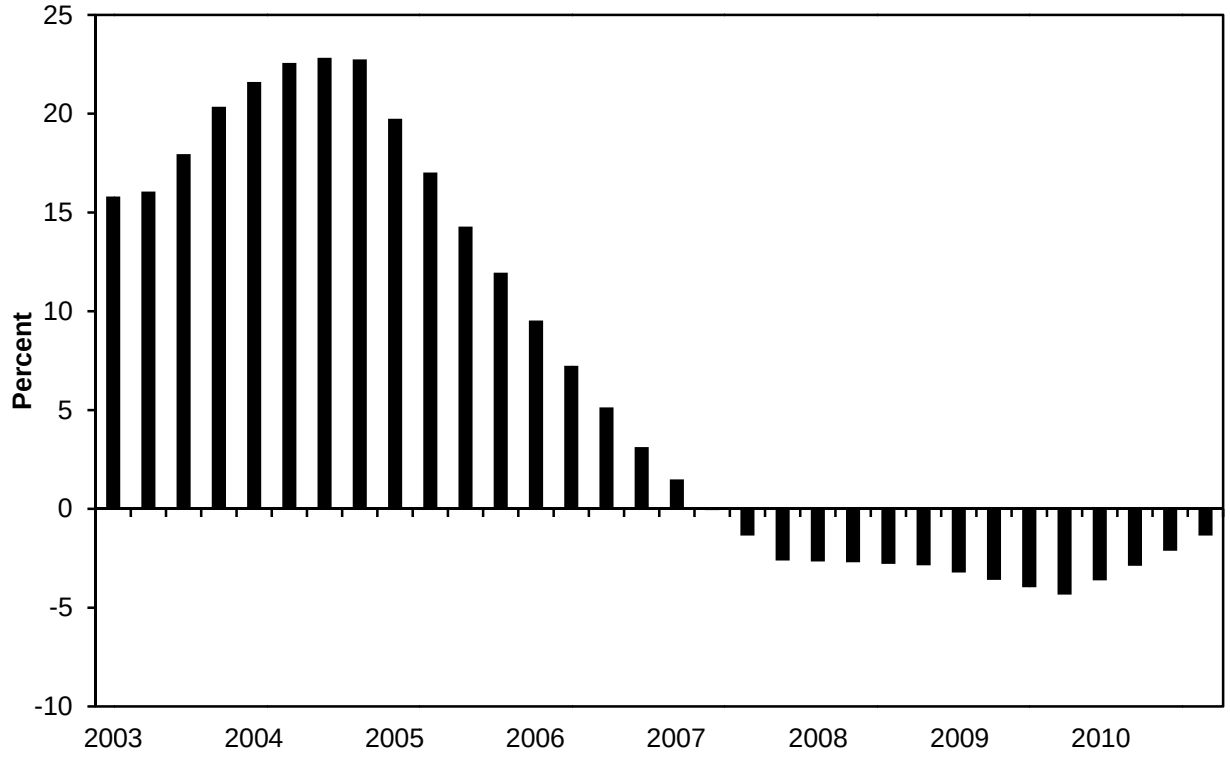
Note: Volume is units of service multiplied by relative value units from the physician fee schedule. Volume for both years is measured on a common scale, with relative value units for 2009.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

- Among broad categories of services, evaluation and management (E&M) services—including office visits and visits to hospital inpatients—account for the largest share of volume. In 2009, E&M was 42.2 percent of the total, followed by other procedures (21.8 percent), imaging (15.2 percent), major procedures (8.8 percent), and tests (5.1 percent). Services in other categories—such as chiropractic—accounted for the remaining 6.9 percent.

- With higher growth rates for some services and lower growth rates for others, the distribution of volume across the service categories has shifted. For instance, as a proportion of total volume, E&M services fell between 2003 and 2008 from 44.3 percent to 42.2 percent. By contrast, imaging's share of total volume for those years rose from 14.2 percent to 15.2 percent.

Chart 7-10. Changes in physicians' professional liability insurance premiums, 2003–2010



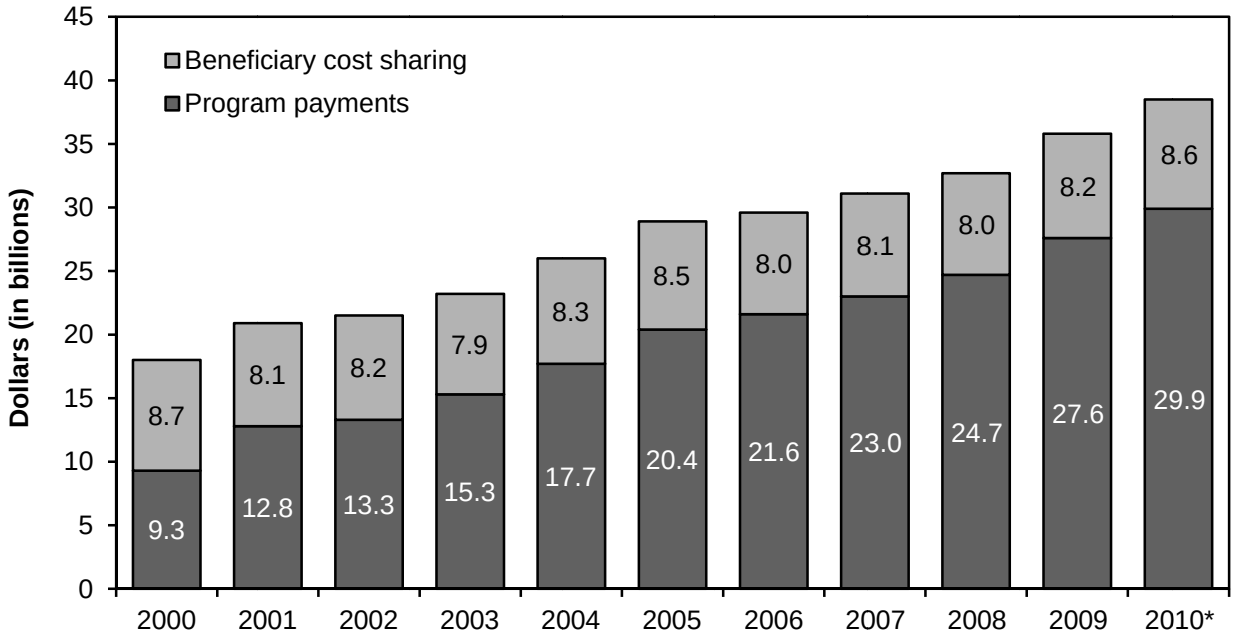
Note: Bars represent a four-quarter moving average percent change.

Source: CMS, Office of the Actuary. Data are from CMS's Professional Liability Physician Premium Survey.

- Professional liability insurance (PLI) accounts for 4.3 percent of total payments under the physician fee schedule. PLI premiums generally follow a cyclical pattern, alternating between periods of low premiums—characterized by high investment returns for insurers and vigorous competition—and high premiums—characterized by declining investment returns and market exit.

- After rapid increases in PLI premiums between 2002 and 2004, premium growth slowed in 2005 and 2006, becoming negative in 2007.

Chart 7-11. Spending on all hospital outpatient services, 2000–2010



Note: Spending amounts are for services covered by the Medicare outpatient prospective payment system and those paid on separate fee schedules (e.g., ambulance services and durable medical equipment) or those paid on a cost basis (e.g., organ acquisition and flu vaccines). They do not include payments for clinical laboratory services.
*Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services (excluding clinical laboratory services) from calendar year 2000 to 2010 increased by 11.5 percent, reaching $38.6 billion. The Office of the Actuary projects continued growth in total spending, averaging 8.2 percent per year from 2007 to 2012.

- A prospective payment system (PPS) for hospital outpatient services was implemented in August 2000. Services paid under the outpatient PPS represent most of the hospital outpatient spending illustrated in this chart, about 92 percent.

- In 2001, the first full year of the outpatient PPS, spending under the PPS was $19.2 billion, including $11.4 billion by the program and $7.7 billion in beneficiary cost sharing. Spending under the outpatient PPS represented 92 percent of the $20.9 billion in spending on hospital outpatient services in 2001. By 2010, spending under the outpatient PPS is expected to rise to $35.3 billion ($27.4 billion program spending; $7.9 billion beneficiary copayments), which is 92 percent of the $38.6 billion in spending on outpatient services in 2010. The outpatient PPS accounted for about 6 percent of total Medicare spending by the program in 2010.

- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 23 percent in 2009. Chart 7-15 provides more detail on coinsurance.

Chart 7-12. Most hospitals provide outpatient services

Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
2002	4,210	94%	84%	93%
2004	3,882	94	86	92
2006	3,651	94	86	91
2008	3,607	94	87	91
2009	3,557	94	89	89
2010	3,518	95	90	89

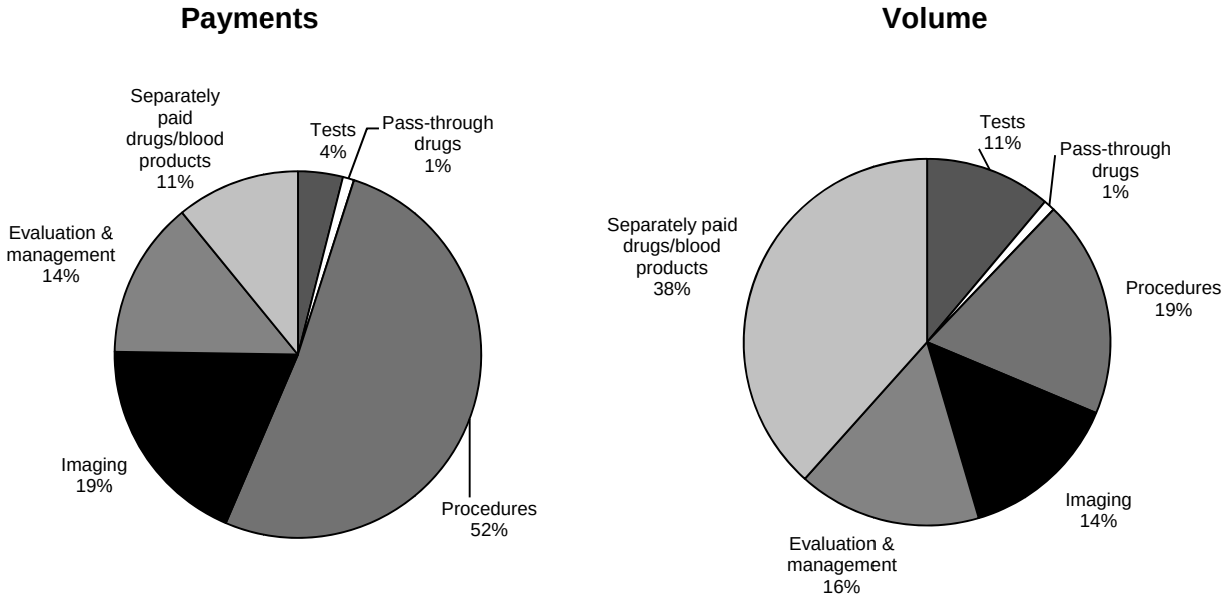
Note: Includes services provided or arranged by short-term hospitals. Excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare's outpatient prospective payment system (PPS) declined from 2001 through 2006, largely due to growth in the number of hospitals converting to critical access hospital status, which allows payment on a cost basis. Since 2006, the number of outpatient PPS hospitals has been more stable. In addition, the percent of hospitals providing outpatient services remained stable; the percent offering outpatient surgery has steadily increased; and the percent offering emergency services has decreased slightly.

- Almost all hospitals in 2010 provide outpatient services (95 percent). The vast majority provides outpatient surgery (90 percent) and emergency services (89 percent).

Chart 7-13. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2009



Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing but do not include hold-harmless payments to rural hospitals. Services are grouped into evaluation and management, procedures, imaging, and tests, according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator. Percentages may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the five standard analytic file of outpatient claims for 2009.

- Hospitals provide many different types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- The payments for services are distributed differently than volume. For example, procedures account for 52 percent of payments but only 19 percent of volume.
- Procedures (e.g., endoscopies, surgeries, skin and musculoskeletal procedures) account for the greatest share of payments for services (52 percent), followed by imaging services (19 percent) and evaluation and management services (14 percent).
- In 2009, separately paid drugs and blood products accounted for 11 percent of payments.

Chart 7-14. Hospital outpatient services with the highest Medicare expenditures, 2009

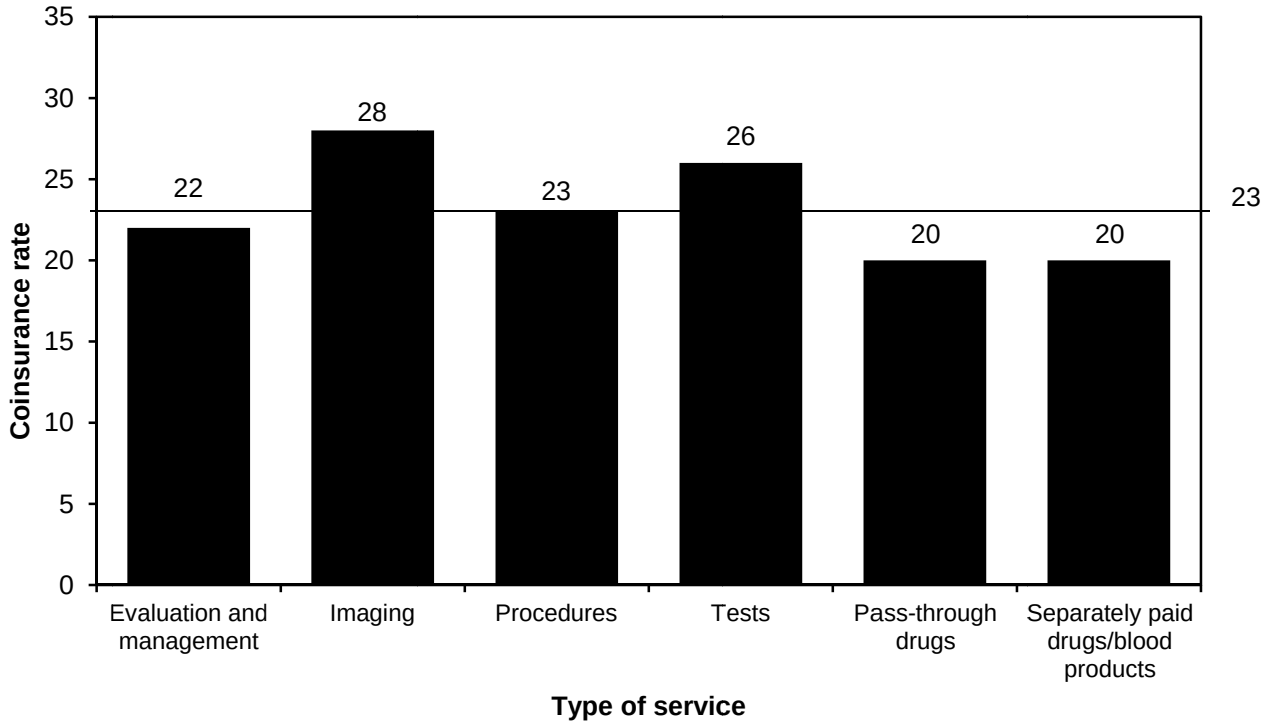
APC Title	Share of payments	Volume (thousands)	Payment rate
Total	47%		
All emergency visits	6	10,988	$180
All clinic visits	4	18,679	72
Diagnostic cardiac catheterization	3	450	2,594
CT and CTA with contrast composite*	3	1,528	635
Cataract procedures with IOL insert	3	540	1,605
Level I plain film except teeth	2	15,581	45
Lower gastrointestinal endoscopy	2	1,146	594
Insertion of cardioverter-defibrillator	2	28	21,140
Level II extended assessment & management composite	2	808	675
Insertion/replacement/repair of cardioverter-defibrillator leads	2	19	28,251
IMRT treatment delivery	2	1,205	411
Computed tomography without contrast	1	2,463	194
Transcatheter placement of intracoronary drug-eluting stents	1	68	7,669
Coronary or noncoronary angioplasty and percutaneous valvuloplasty	1	180	3,195
Level II cardiac imaging	1	584	774
Level I upper gastrointestinal procedures	1	922	572
CT and CTA without contrast composite*	1	1,011	416
Transcatheter placement of intravascular shunts*	1	73	6,094
Level II echocardiogram without contrast except transesophageal	1	896	431
Level II laparoscopy	1	131	3,060
MRI and magnetic resonance angiography without contrast material	1	994	348
Level III nerve injections	1	841	474
Rituximab cancer treatment	1	6,060	525
MRI and magnetic resonance angiography without contrast followed by contrast	1	598	539
Level II radiation therapy	1	2,077	152
Average APC		344	143

Note: APC (ambulatory payment classification), CT (computed tomography), CTA (computed tomography angiography), IOL (intraocular lens), IMRT (intensity-modulated radiation therapy), MRI (magnetic resonance imaging). The payment rates for "All emergency visits" and "All clinic visits" are weighted averages of payment rates from five APCs.
*Did not appear on the list for 2008.

Source: MedPAC analysis of 5 percent analytic files of outpatient claims for calendar year 2009.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 7-15. Medicare coinsurance rates, by type of hospital outpatient service, 2009



Note: Services were grouped into categories of evaluation and management, imaging, procedures, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicators.

Source: MedPAC analysis of the 5 percent standard analytic files of outpatient claims for 2009.

- Historically, beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented a large share of total payments over time.
- In adopting the outpatient prospective payment system, the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments will decline over time.
- The coinsurance rate is different for each service. Some services, such as imaging, have relatively high rates of coinsurance—28 percent. Other services, such as evaluation and management services, have coinsurance rates of 22 percent.
- In 2009, the average coinsurance rate was about 23 percent.

Chart 7-16. Effects of hold-harmless and SCH transfer payments on hospitals' outpatient revenue, 2007–2009

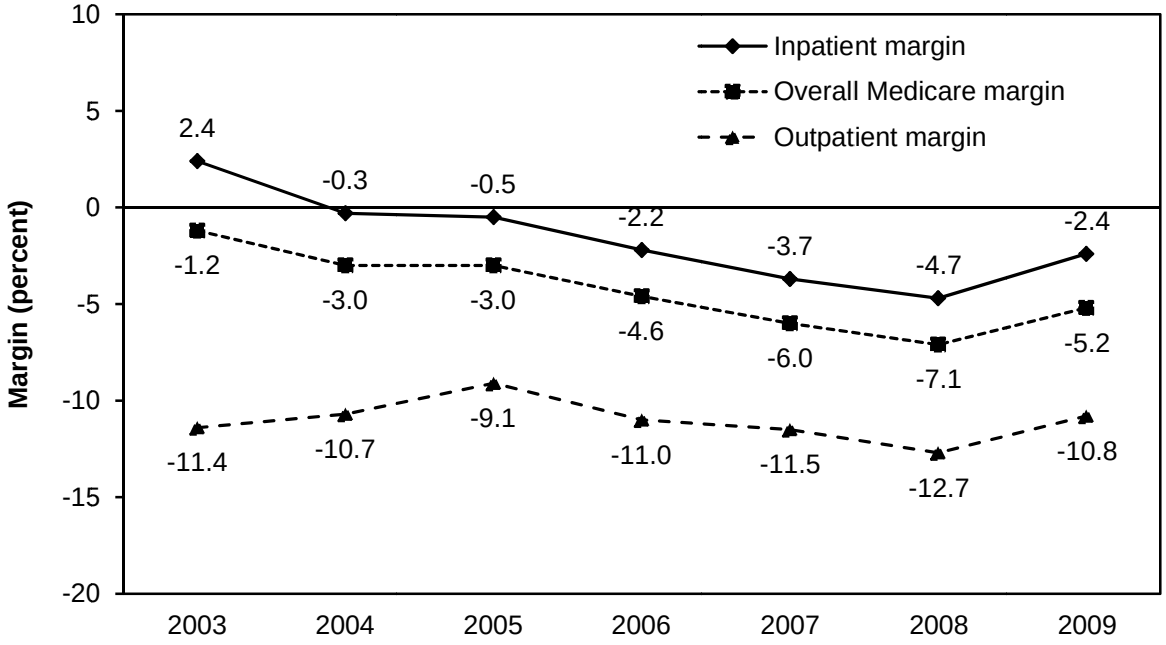
Hospital group	2007 Number of hospitals	2007 Share of payments from hold harmless and SCH transfer	2008 Number of hospitals	2008 Share of payments from hold harmless and SCH transfer	2009 Number of hospitals	2009 Share of payments from hold harmless and SCH transfer
All hospitals	3,292	0.2%	3,197	0.2%	3,143	0.3%
Urban	2,349	–0.4	2,276	–0.4	2,241	–0.4
Rural SCHs	409	5.8	397	5.9	389	7.1
Rural ≤100 beds	381	2.9	373	3.1	363	3.1
Other rural	153	–0.4	151	–0.4	150	–0.4
Major teaching	272	–0.3	265	–0.3	260	–0.3
Other teaching	762	–0.1	745	–0.1	742	–0.2
Nonteaching	2,258	0.6	2,187	0.6	2,141	0.8

Note: SCH (sole community hospital).

Source: MedPAC analysis of Medicare Cost Report files from CMS.

- Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000. Previously, Medicare paid for hospital outpatient services on the basis of hospital costs. Recognizing that some hospitals might receive lower payments under the outpatient PPS than under the earlier system, the Congress established transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS.
- Transitional corridor payments expired for most hospitals at the end of 2003. However, some rural hospitals continue to receive a special category of transitional corridor payments called "hold harmless." Qualifying hospitals receive the greater of the payments they would have received from the previous system or the actual outpatient PPS payments.
- Hospitals that qualified for hold-harmless payments in 2004 and 2005 included sole community hospitals (SCHs) located in rural areas and other small rural hospitals (100 or fewer beds). After 2005, small rural hospitals continued to be eligible for hold-harmless payments but SCHs no longer qualified. However, in 2006, CMS implemented a policy (the "SCH transfer") that increased outpatient payments to rural SCHs by 7.1 percent above the standard rates. This policy is budget neutral by reducing payments to all other hospitals by 0.4 percent. Finally, the Congress reestablished hold-harmless payments for SCHs that have 100 or fewer beds.
- Hold-harmless payments and the SCH transfer represented 0.2 percent of total outpatient PPS payments for all hospitals in 2007. However, the percentage of total outpatient payments from these policies was 5.8 percent for rural SCHs and 2.9 percent for small rural hospitals. Data from 2008 and 2009 indicate transfer and hold-harmless payments to rural SCHs were 5.9 percent of their outpatient revenue in 2008 and 7.1 percent in 2009. Small rural hospitals continued to benefit from hold-harmless payments in 2008 and 2009. These payments were 3.1 percent of their total outpatient payments in both years.

Chart 7-17. Medicare hospital outpatient, inpatient, and overall Medicare margins, 2003–2009



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation (not paid under the prospective payment system) services, hospital-based skilled nursing facilities and home health services, and graduate medical education.

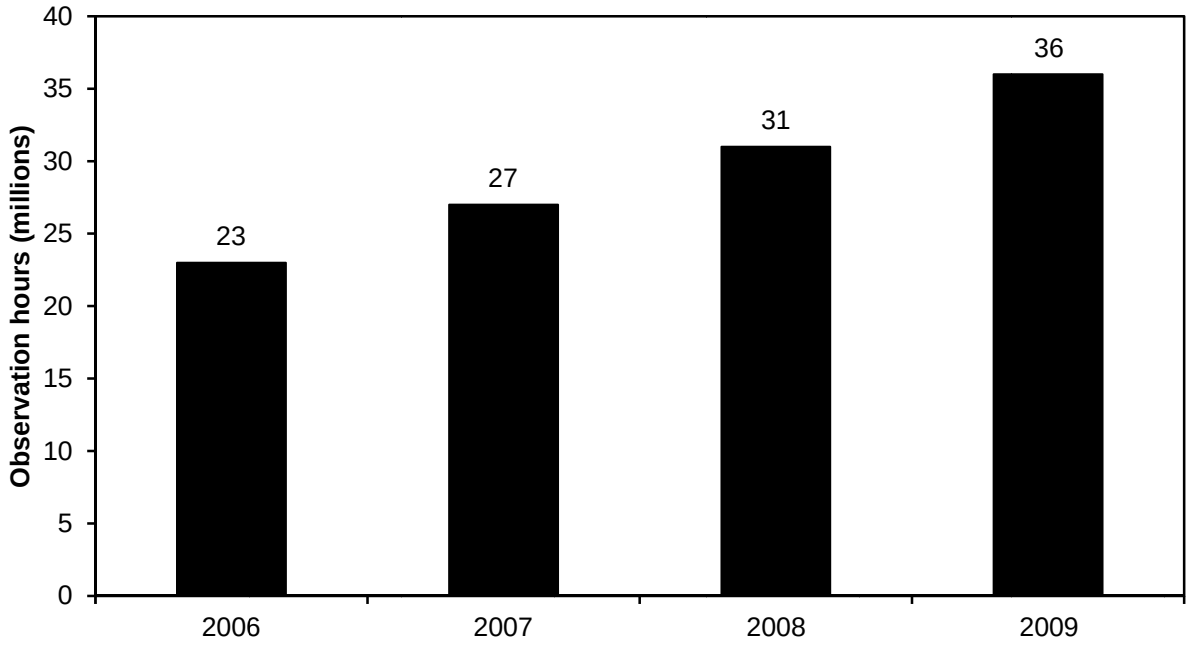
Source: MedPAC analysis of Medicare cost report data from CMS.

- Hospital outpatient margins vary. In 2009, while the aggregate margin was –10.8 percent, 25 percent of hospitals had margins of –22.3 percent or lower, and 25 percent had margins of –1.6 percent or higher. Outpatient margins also differed widely across hospital categories.

- Given hospital accounting practices, margins for hospital outpatient services must be considered in the context of Medicare payments and hospital costs for the full range of services provided to Medicare beneficiaries. Hospitals allocate overhead to all services, so we generally consider costs and payments overall.

- The improved margin in 2009 may be due to relatively low cost growth and expansion of hold-harmless payments to sole community hospitals (SCHs). After increasing from 2003 to 2004 and 2005, the outpatient margin declined in 2006, reflecting a change in Medicare's reimbursement for Part B drugs and an end to hold-harmless payments to SCHs (which were reestablished in 2009). The margin declined again in 2007 and 2008, which may be partly due to lower hold-harmless payments for hospitals that still qualify for them.

Chart 7-18. Number of observation hours has increased, 2006–2009



Source: MedPAC analysis of outpatient prospective payment system claims that CMS uses to set payment rates, 2006–2009.

- Hospitals use observation care to determine whether a patient should be hospitalized for inpatient care or sent home.
- Medicare began providing separate payments to hospitals for some observation services on April 1, 2002. Previously, the observation services were packaged into the payments for the emergency room or clinic visits that occur with observation care.
- The number of observation hours (both packaged and separately paid) has increased substantially from about 23 million in 2006 to 36 million in 2009. Before 2006, it was difficult to count the total number of observation hours because hospitals were not required to record on claims the number of hours for packaged observation hours.

Chart 7-19. Number of Medicare-certified ASCs increased by 41 percent, 2003–2010

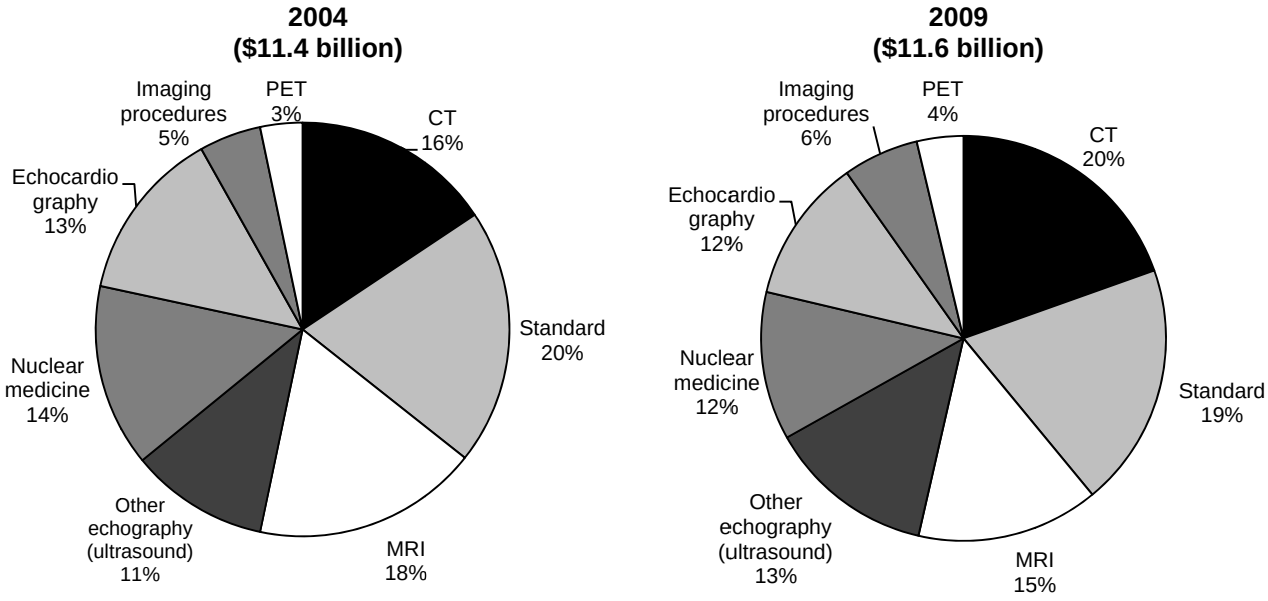
	2003	2004	2005	2006	2007	2008	2009	2010
Medicare payments (billions of dollars)	$2.2	$2.5	$2.7	$2.8	$2.9	$3.1	$3.2	$3.4
Number of centers	3,779	4,067	4,362	4,608	4,879	5,095	5,217	5,316
New centers	366	368	354	331	344	281	213	152
Exiting centers	66	80	59	85	73	65	91	53
Net percent growth in number of centers from previous year	7.6%	7.6%	7.3%	5.6%	5.9%	4.4%	2.4%	1.9%
Percent of all centers that are:								
For profit	95	96	96	96	96	96	96	97
Nonprofit	5	4	4	4	4	4	3	3
Urban	87	87	87	88	88	88	88	88
Rural	13	13	13	12	12	12	12	12

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2010 are preliminary and subject to change. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of provider of services files from CMS, 2010. Payment data are from CMS, Office of the Actuary.

- Ambulatory surgical centers (ASCs) are entities that furnish only outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify minimum facility standards.
- In 2008, Medicare began using a new payment system for ASC services that is based on the hospital outpatient prospective payment system. ASC rates are less than hospital outpatient rates. In contrast to the old ASC system, which had only nine procedure groups, the new system has several hundred procedure groups.
- Total Medicare payments for ASC services increased by 6.5 percent per year, on average, from 2003 through 2010. Payments per fee-for-service beneficiary grew by 6.6 percent per year during this period. Between 2009 and 2010, total payments rose by 5.6 percent and payments per beneficiary grew by 4.2 percent.
- The number of Medicare-certified ASCs grew at an average annual rate of 5.0 percent from 2003 through 2010. Each year from 2003 through 2010, an average of 301 new Medicare-certified facilities entered the market, while an average of 72 closed or merged with other facilities.

Chart 7-20. Medicare spending for imaging services under the physician fee schedule, by type of service, 2004 and 2009

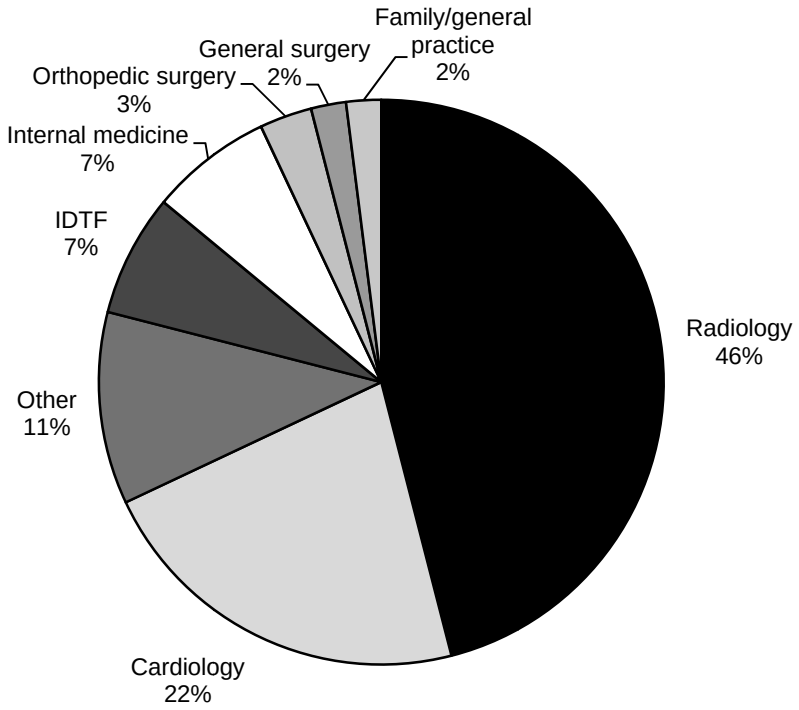


Note: CT (computed tomography), MRI (magnetic resonance imaging), PET (positron emission tomography). Standard imaging includes chest, musculoskeletal, and breast X-rays. Imaging procedures include stereoscopic X-ray guidance for delivery of radiation therapy, fluoroguide for spinal injection, and other interventional radiology procedures. Medicare payments include program spending and beneficiary cost sharing for physician fee-schedule imaging services. Payments include carrier-priced codes but exclude radiopharmaceuticals. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2004 and 2009.

- About one-third of Medicare spending for imaging under the physician fee schedule in 2009 was for computed tomography and magnetic resonance imaging (MRI) studies.
- Between 2000 and 2009, physician fee-schedule spending for imaging services grew by 5.9 percent per year per fee-for-service (FFS) beneficiary.
- Imaging spending declined from $13.2 billion in 2006 to $11.4 billion in 2007, largely as a result of a provision in the Deficit Reduction Act of 2005 that capped physician fee-schedule rates for the technical component of imaging services at the level of hospital outpatient rates. However, the number and complexity of imaging studies grew by 3.8 percent per FFS beneficiary from 2006 to 2007.
- Imaging spending resumed its growth in 2008, increasing by 3.8 percent per FFS beneficiary to $11.7 billion. Although spending declined slightly from 2008 to 2009 (from $11.7 billion to $11.6 billion), the number and complexity of imaging services grew by 2.0 percent per FFS beneficiary. The slight decline in spending was largely due to changes in practice expense relative value units for imaging services and the adoption of a new comprehensive code for echocardiography.

Chart 7-21. Radiologists received nearly half of physician fee-schedule payments for imaging services, 2009



Note: IDTF (independent diagnostic testing facility). Medicare payments include program spending and beneficiary cost sharing for physician fee-schedule imaging services. Payments include carrier-priced codes but exclude radiopharmaceuticals. Total fee-schedule imaging spending was $11.6 billion in 2009. IDTFs are independent of a hospital and physician's office and provide only outpatient diagnostic services. The other category includes urology, ophthalmology, gastroenterology, anesthesiology, and other specialties.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2009.

- Imaging services paid under Medicare's physician fee schedule involve two parts: the technical component, which covers the cost of the equipment, supplies, and nonphysician staff, and the professional component, which covers the physician's work in interpreting the study and writing a report. A provider who performs both the technical and the professional component of a study bills Medicare for a global service.

- Although radiologists received over three-quarters of total physician fee-schedule payments for professional component services in 2009, they accounted for much smaller shares of spending for global services (34 percent) and technical component services (14 percent).

- Between 2004 and 2009, the share of total imaging payments for independent diagnostic testing facilities, family/general practice, cardiology, and internal medicine declined. The share of imaging payments for radiology stayed about the same, and the share for other providers (such as general surgery and orthopedic surgery) increased.

Web links. Ambulatory care

Physicians

- For more information on Medicare's payment system for physician services, see MedPAC's Payment Basics series.

  http://medpac.gov/documents/MedPAC_Payment_Basics_10_Physician.pdf

- Chapter 4 of the MedPAC March 2011 Report to the Congress and Appendix A of the June 2011 Report to the Congress provide additional information on physician services.

  http://www.medpac.gov/chapters/Mar11_Ch04.pdf
  http://www.medpac.gov/chapters/Jun11_AppA.pdf

- MedPAC's congressionally mandated report, *Assessing Alternatives to the Sustainable Growth Rate (SGR) System*, examines the SGR and analyzes alternative mechanisms for controlling physician expenditures under Medicare.

  http://www.medpac.gov/documents/Mar07_SGR_mandated_report.pdf

- Congressional testimony by the chairman and executive director of MedPAC discusses payment for physician services in the Medicare program. This includes:

  Payments to selected fee-for-service providers (May 15, 2007)
  http://www.medpac.gov/documents/051507_WandM_Testimony_MedPAC_FFS.pdf

  Options to improve Medicare's payments to physicians (May 10, 2007)
  http://www.medpac.gov/documents/051007_Testimony_MedPAC_physician_payment.pdf

  Assessing alternatives to the sustainable growth rate system (March 6, 2007)
  http://www.medpac.gov/documents/030607_W_M_testimony_SGR.pdf

  Assessing alternatives to the sustainable growth rate system (March 6, 2007)
  http://www.medpac.gov/documents/030607_E_C_testimony_SGR.pdf

  Assessing alternatives to the sustainable growth rate system (March 1, 2007)
  http://www.medpac.gov/documents/030107_Finance_testimony_SGR.pdf

  MedPAC recommendations on imaging services (July 18, 2006)
  http://medpac.gov/documents/071806_Testimony_imaging.pdf

  Medicare payment to physicians (July 25, 2006)
  http://medpac.gov/documents/072506_Testimony_physician.pdf

- The 2011 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds provides details on historical and projected spending on physician services.

  http://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf

- The Government Accountability Office issued a report in August 2009 about access to physician services within Medicare.

  http://www.gao.gov/new.items/d09559.pdf

- The Center for Studying Health System Change also conducts research on patient access to health care.

  http://www.hschange.org

Hospital outpatient services

- For more information on Medicare's payment system for hospital outpatient services, see MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_opd.pdf

- Chapter 3 of the MedPAC March 2011 Report to the Congress provides information on the status of hospital outpatient departments including supply, volume, profitability, and cost growth.

  http://www.medpac.gov/chapters/Mar11_Ch03.pdf

- Section 2A of the MedPAC March 2006 Report to the Congress provides information on the current status of hold-harmless payments and other special payments for rural hospitals.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02a.pdf

- Chapter 3A of the MedPAC March 2004 Report to the Congress provides additional information on hospital outpatient services, including outlier and transitional corridor payments.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf

- More information on new technology and pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress.

  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf

Ambulatory surgical centers

- For more information on Medicare's payment system for ambulatory surgical centers, see MedPAC's Payment Basics series.

  http://medpac.gov/documents/MedPAC_Payment_Basics_10_ASC.pdf

- Chapter 5 of the MedPAC March 2011 Report to the Congress provides additional information on ambulatory surgical centers.

  http://medpac.gov/chapters/Mar11_Ch05.pdf